STATE OF MINNESOTA
DEPARTMENT OF COMMERCE
1987 LEGISLATION - INSURANCE

BULLETIN 87-4
Issued this 2nd day
of July, 1987

TO: All Insurers Licensed to Write Life
or Health Insurance in Minnesota

Included and made a part of this Bulletin are the following:

- Those sections of the 1987 Omnibus Insurance Act (Chapter 337) which affect companies writing Life and Health insurance.
- Most of those sections of the Act which affect all companies.

We have not produced Sec. 66 because it was long. However, the changes were not extensive, Sec. 66 amended MN. Stat. 62E.06, Subd. 1 by adding #15 under "b". The words added were "services of an occupational therapist." In addition, part "g" was added under Subd. 1 and this stated: "Outpatient mental health coverage is subject to sections 62A.152, Subd. 2."

We urge you to review the entire Act as soon as possible. Some sections were effective on the day following final enactment. Many of the changes are effective on August 1, 1987, and many of these changes will require the filings of forms. Sec. 132 of the Act lists the effective dates of each section and Sec. 132 is included in the material attached.

The information furnished to you does not include every section of Chapter 337. Also, there may be other statutes that will affect your operations. You should get copies of all such laws.

Michael A. Hatch
Commissioner of Commerce

GENERAL

Sec. 5. Minnesota Statutes 1986, section 60A.17, subdivision 2c, is amended to read:

Subd. 2c. [~~MANDATORY~~ TEMPORARY LICENSES.] The commissioner ~~shall~~ may grant a temporary insurance agent's license to a person who has ~~submitted an application for a resident license~~ which ~~is~~ accepted by the commissioner and who has successfully completed the examination, if any, required by the commissioner. The temporary license ~~shall~~ may be granted ~~no later than~~ as of the date upon which the applicant receives written notice from the commissioner that ~~the application for resident license has been accepted by the commissioner and that~~ the person has passed any required examination. A temporary license will permit the applicant to act as an insurance agent for the original appointing insurer for the class of business specified therein until the earlier of (a) receipt by the applicant of the resident license, or (b) the expiration of 90 days from the date on which the temporary license was granted.

Sec. 6. Minnesota Statutes 1986, section 60A.17, subdivision 11, is amended to read:

Subd. 11. [~~LIFE COMPANY AGENTS~~ INSURER'S AGENT.] Any person who ~~shall solicit an application for~~ solicits insurance ~~upon the life of another shall, in any controversy between the assured or the assured's beneficiary and the company issuing any policy upon such application, be regarded as~~ is the agent of the ~~company~~ insurer and not the agent of the ~~assured~~ insured.

Sec. 8. Minnesota Statutes 1986, section 60A.1701, subdivision 5, is amended to read:

Subd. 5. [POWERS OF THE ADVISORY TASK FORCE.] (a) Applications ~~for accreditation of each course and~~ for approval of individuals responsible for monitoring course offerings must be submitted to the commissioner on forms prescribed by the commissioner and must be accompanied by a fee of not more than $50 payable to the state of Minnesota for deposit in the general fund. A fee of $5 for each hour or fraction of one hour of course approval sought must be forwarded with the application for course approval. If the advisory task force is created, it shall make recommendations to the commissioner regarding the accreditation of courses sponsored by institutions, both public and private, which satisfy the criteria established by this section, the number of credit hours to be assigned to the courses, and rules which may be promulgated by the commissioner. The advisory task force shall seek out and encourage the presentation of courses.

(b) If the advisory task force is created, it shall make recommendations and provide subsequent evaluations to the commissioner regarding procedures for reporting compliance with

the minimum education requirement.

Sec. 9. Minnesota Statutes 1986, section 60A.1701, subdivision 7, is amended to read:

Subd. 7. [CRITERIA FOR COURSE ACCREDITATION.] (a) The commissioner may accredit a course only to the extent it is designed to impart substantive and procedural knowledge of the insurance field. The burden of demonstrating that the course satisfies this requirement is on the individual or organization seeking accreditation. The commissioner shall approve any educational program approved by Minnesota Continuing Legal Education relating to the insurance field.

(b) The commissioner may not accredit a course:

(1) that is designed to prepare students for a license examination;

(2) in mechanical office or business skills, including typing, speedreading, use of calculators, or other machines or equipment;

(3) in sales promotion, including meetings held in conjunction with the general business of the licensed agent; or

(4) in motivation, the art of selling, psychology, or time management;

(5) unless the student attends classroom instruction conducted by an instructor approved by the department of commerce; or

(6) which can be completed by the student at home or outside the classroom without the supervision of an instructor approved by the department of commerce.

Sec. 10. Minnesota Statutes 1986, section 60A.1701, subdivision 8, is amended to read:

Subd. 8. [MINIMUM EDUCATION REQUIREMENT.] Each person subject to this section shall complete annually a minimum of 20 credit hours of courses accredited by the commissioner. Any person teaching or lecturing at an accredited course qualifies for 1-1/2 times the number of credit hours that would be granted to a person completing the accredited course. ~~Credit-hours-over 29-earned-in-any-one-year-may-be-carried-forward-for-the following-two-years.--The-commissioner-may-recognize-accredited courses-completed-in-1999,-1994,-or-1995-for-the-minimum education-requirement-for-1995.~~ No more than ten credit hours per year may be credited to a person for courses sponsored by, offered by, or affiliated with an insurance company or its agents. Courses sponsored by, offered by, or affiliated with an insurance company or agent may restrict its students to agents

of the company or agency.

Sec. 11, Minnesota Statutes 1986, section 50A.196, is amended to read:

60A,196 [DEFINITIONS.]

Unless the context otherwise requires, the following terms have the meanings given them for the purposes of sections 60A.195 to 60A.209:

(a) "Surplus lines insurance" means insurance placed with an insurer permitted to transact the business of insurance in this state only pursuant to sections 60A.195 to 60A.209.

(b) "Eligible surplus lines insurer" means an insurer recognized as eligible to write insurance business under sections 60A.195 to 60A.209 but not licensed by any other Minnesota law to transact the business of insurance.

(c) "Ineligible surplus lines insurer" means an insurer not recognized as an eligible surplus lines insurer pursuant to sections 60A.195 to 60A.209 and not licensed by any other Minnesota law to transact the business of insurance. "Ineligible surplus lines insurer" includes a risk retention group as defined under the Liability Risk Retention Act, Public Law Number 99-563.

(d) "Surplus lines licensee" or "licensee" means a person licensed under sections 60A,195 to 60A.209 to place insurance with an eligible or ineligible surplus lines insurer.

(e) "Association" means an association registered under section 60A.208.

(f) "Alien insurer" means any insurer which is incorporated or otherwise organized outside of the United States.

(g) "Insurance laws" means chapters 60 to 79 inclusive.

Sec. 12. Minnesota Statutes 1986, section 60A.198, subdivision 3, is amended to read:

Subd. 3. [PROCEDURE FOR OBTAINING LICENSE.] A person licensed as a-resident an agent in this state pursuant to other law may obtain a surplus lines license by doing the following:

(a) filing an application in the form and with the information the commissioner may reasonably require to determine the ability of the applicant to act in accordance with sections 60A.195 to 60A.209;

(b) maintaining a-resident-agent an agent's license in this state;

(c) delivering to the commissioner a financial guarantee bond from a surety acceptable to the commissioner for the greater of the following:

(1) $5,000; or

(2) the largest semiannual surplus lines premium tax liability incurred by the applicant in the immediately preceding five years; and

(d) agreeing to file with the commissioner of revenue no later than February 15 and August 15 annually, a sworn statement of the charges for insurance procured or placed and the amounts returned on the insurance canceled under the license for the preceding six-month period ending December 31 and June 30 respectively, and at the time of the filing of this statement, paying the commissioner a tax on premiums equal to three percent of the total written premiums less cancellations; and

(e) annually paying a fee as prescribed by section 60A.14, subdivision 1, paragraph (c), clause (11).

Sec. 14. Minnesota Statutes 1986, section 60A.23, subdivision 8, is amended to read:

Subd. 8. [SELF-INSURANCE OR INSURANCE PLAN ADMINISTRATORS; WHO ARE VENDORS OF RISK MANAGEMENT SERVICES.] (1) [SCOPE.] This subdivision applies to any vendor of risk management services and to any entity which administers, for compensation, a self-insurance or insurance plan. This subdivision does not apply (a) to an insurance company authorized to transact insurance in this state, as defined by section 60A.06, subdivision 1, clauses (4) and (5); (b) to a service plan corporation, as defined by section 62C.02, subdivision 5; (c) to a health maintenance organization, as defined by section 62D,02, subdivision 4; (d) to an employer directly operating a self-insurance plan for its employees' benefits; or (e) to an entity which administers a program of health benefits established pursuant to a collective bargaining agreement between an employer, or group or association of employers, and a union or unions.

(2) [DEFINITIONS.] For purposes of this subdivision the following terms have the meanings given them.

(a) "Administering a self-insurance or insurance plan" means (i) processing, reviewing or paying claims, (ii) establishing or operating funds and accounts, or (iii) otherwise providing necessary administrative services in connection with the operation of a self-insurance or insurance plan.

(b) "Employer" means an employer, as defined by section 62E.02, subdivision 2.

(c) "Entity" means any association, corporation, partnership, sole proprietorship, trust, or other business entity engaged in or transacting business in this state.

(d) "Self-insurance or insurance plan" means a plan providing life, medical or hospital care, accident, sickness or disability insurance, as an employee fringe benefit, or a plan providing liability coverage for any other risk or hazard, which is or is not directly insured or provided by a licensed insurer, service plan corporation, or health maintenance organization.

(e) "Vendor of risk management services" means an entity providing for compensation actuarial, financial management, accounting, legal or other services for the purpose of designing and establishing a self-insurance or insurance plan for an employer.

(3) [LICENSE.] No vendor of risk management services or entity administering a self-insurance or insurance plan may transact this business in this state unless it is licensed to do so by the commissioner. An applicant for a license shall state in writing the type of activities it seeks authorization to engage in and the type of services it seeks authorization to provide. The license may be granted only when the commissioner is satisfied that the entity possesses the necessary organization, background, expertise, and financial integrity to supply the services sought to be offered. The commissioner may issue a license subject to restrictions or limitations upon the authorization, including the type of services which may be supplied or the activities which may be engaged in. The license fee is $100. All licenses are for a period of two years.

(4) [REGULATORY RESTRICTIONS; POWERS OF THE COMMISSIONER.] To assure that self-insurance or insurance plans are financially solvent, are administered in a fair and equitable fashion, and are processing claims and paying benefits in a prompt, fair, and honest manner, vendors of risk management services and entities administering insurance or self-insurance plans are subject to the supervision and examination by the commissioner. Vendors of risk management services, entities administering insurance or self-insurance plans, and insurance or self-insurance plans established or operated by them are subject to the trade practice requirements of sections 72A.19 to 72A.30.

(5) [RULE MAKING AUTHORITY.] To carry out the purposes of this subdivision, the commissioner may adopt rules, including emergency rules, pursuant to sections 14.01 to ~~14.79~~ 14.69. These rules may:

(a) establish reporting requirements for administrators of insurance or self-insurance plans;

(b) establish standards and guidelines to assure the adequacy of financing, reinsuring, and administration of

insurance or self-insurance plans;

(c) establish bonding requirements or other provisions assuring the financial integrity of entities administering insurance or self-insurance plans; or

(d) establish other reasonable requirements to further the purposes of this subdivision.

Sec. 115. [72A.125] [RENTAL VEHICLE PERSONAL ACCIDENT INSURANCE; SPECIAL REQUIREMENTS.]

Subdivision 1. [DEFINITION.] (a) "Auto rental company" means a corporation, partnership, individual, or other person that is engaged primarily in the renting of motor vehicles at per diem rates.

(b) "Rental vehicle personal accident insurance" means accident only insurance providing accidental death benefits, dismemberment benefits and/or reimbursement for medical expenses which is issued by an insurer authorized in this state to issue accident and health insurance. These coverages are nonqualified plans under chapter 62E.

Subd. 2. [SALE BY AUTO RENTAL COMPANIES.] An auto rental company that offers or sells rental vehicle personal accident insurance in this state in conjunction with the rental of a vehicle shall only sell these products if the forms and rates have met the relevant requirements of section 62A.02, taking into account the possible infrequency and severity of loss that may be incurred. Sections 60A.17 and 60A.1701 do not apply if the persons engaged in the sale of these products are employees of the auto rental company who do not receive commissions or other remuneration for selling the product in addition to their regular compensation. Compensation may not be determined in any part by the sale of insurance products. The auto rental company before engaging in the sale of the product must file with the commissioner the following documents:

(1) an appointment of the commissioner as agent for service of process;

(2) an agreement that the auto rental company assumes all responsibility for the authorized actions of all unlicensed employees who sell the insurance product on its behalf in conjunction with the rental of its vehicles;

(3) an agreement that the auto rental company with respect to itself and its employees will be subject to this chapter regarding the marketing of the insurance products and the conduct of those persons involved in the sale of insurance products in the same manner as if it were a licensed agent.

An auto rental company failing to file the documents in

clauses (1) to (3) is guilty of an individual violation as to the unlicensed sale of insurance for each sale that occurs after the effective date of this section until they make the required filings. Each individual sale after the effective date of this section and prior to the filing required by this section is subject to, in addition to any other penalties allowable by law, up to a $100 per violation fine. Further, the sale of the insurance product by an auto rental company or any employee or agent of the company after the effective date of this section without having complied with this section shall be deemed to be in acceptance of the provisions of this section.

Insurance sold pursuant to this subdivision must be limited in availability to rental vehicle customers though coverage may extend to the customer, other drivers, and passengers using or riding in the rented vehicles; and limited in duration to a period equal to and concurrent with that of the vehicle rental.

Persons purchasing rental vehicle personal accident insurance may be provided a certificate summarizing the policy provisions in lieu of a copy of the policy if a copy of the policy is available for inspection at the place of sale and a free copy of the policy may be obtained from the auto rental company's home office.

The commissioner may, after a hearing, revoke an auto rental company's right to operate under this section if the company has repeatedly violated the insurance laws of this state and the revocation is in the public interest.

Sec. 116. Minnesota Statutes 1986, section 72A.20, subdivision 11, is amended to read:

Subd. 11. [APPLICATION TO CERTAIN SECTIONS.] Violating any provision of the following sections of this chapter not set forth in ~~subdivisions 1 to 15~~ this section shall constitute an unfair method of competition and an unfair and deceptive act or practice: sections 72A.12, subdivisions 2, 3, and 4, 72A.16, subdivision 2, 72A.03 and 72A.04, 72A.08, subdivision 1 as modified by section 72A.08, subdivision 4, and 65B.13.

Sec. 117. Minnesota Statutes 1986, section 72A.20, subdivision 17, is amended to read:

Subd. 17. [~~RETURN OF PREMIUMS UPON DEATH OR INSURED~~.] (a) Refusing, upon surrender of an individual policy of life insurance, to refund to the estate of the insured all unearned premiums paid on the policy covering the insured as of the time of the insured's death if the unearned premium is for a period of more than one month.

The insurer may deduct from the premium any previously accrued claim for loss or damage under the policy.

For the purposes of this section, a premium is unearned during the period of time the insurer has not been exposed to any risk of loss.

(b) Refusing, upon termination or cancellation of a policy of automobile insurance under section 65B.14, subdivision 2, or a policy of homeowner's insurance under section 65A.27, subdivision 4, or a policy of accident and sickness insurance under section 62A.01, or a policy of comprehensive health insurance under chapter 62E, to refund to the insured all unearned premiums paid on the policy covering the insured as of the time of the termination or cancellation if the unearned premium is for a period of more than one month.

The insurer may deduct from the premium any previously accrued claim for loss or damage under the policy.

For purposes of this section, a premium is unearned during the period of time the insurer has not been exposed to any risk of loss.

Sec. 118. Minnesota Statutes 1986, section 72A.20, is amended by adding a subdivision to read:

Subd. 18. [IMPROPER BUSINESS PRACTICES.] (a) Improperly withholding, misappropriating, or converting any money belonging to a policyholder, beneficiary, or other person when received in the course of the insurance business; or (b) engaging in fraudulent, coercive, or dishonest practices in connection with the insurance business, shall constitute an unfair method of competition and an unfair and deceptive act or practice.

Sec. 128. [RULE CHANGES.]

The commissioner shall adopt rule amendments to Minnesota Rules, chapter 2725, as necessary to effect the changes required by the legislature in sections 8 to 10.

These rules are exempt from the rulemaking provisions of chapter 14. The commissioner must comply with section 14.38, subdivision 7, when adopting these rule amendments.

Sec. 130. [SEVERABILITY.]

The provisions of Minnesota Statutes, section 645.20 apply to this act.

Sec. 131, [REPEALER.]

Minnesota Statutes 1986, sections 62A,12; and 67A,43, subdivision 3, are repealed.

Minnesota Rules, parts 2700.2400; 2700.2410; 2700.2420; 2700.2430; and 2700.2440, are repealed.

Section 123 is repealed effective July 1, 1988, if the project implementation phase has not begun by that date.

Sec. 132. [EFFECTIVE DATE.]

Section 10 is effective May 31, 1987. Credits earned and reported to the department before May 31, 1988, may be carried forward and used to fulfill continuing education requirements until May 31, 1989.

Sections 2, 5, 6, 15 to 20, 43, 57 to 63, 69 to 75, 77, 81, 82, 87, 102, 116, and 122 to 125 are effective the day following final enactment.

Section 126 is effective August 1, 1987, and applies to claims arising from incidents occurring on or after that date.

LIFE AND HEALTH

Sec. 3. [60A.084] [NOTIFICATION ON GROUP POLICIES.]

An employer providing life or health benefits may not change benefits, limit coverage, or otherwise restrict participation until the certificate holder or enrollee has been notified of any changes, limitations, or restrictions. Notice in a format which meets the requirements of the Employee Retirement Income Security Act, 29 U.S.C.A., sections 1001 to 1461, is satisfactory for compliance with this section.

Sec. 42. [61A.092] [CONTINUATION OF COVERAGE FOR LIFE INSURANCE.]

Subdivision 1. [CONTINUATION OF COVERAGE.] Every group insurance policy issued or renewed within this state after August 1, 1987, providing coverage for life insurance benefits shall contain a provision that permits covered employees who are voluntarily or involuntarily terminated or laid off from their employment, if the policy remains in force for any active employee of the employer, to elect to continue the coverage for themselves and their dependents.

An employee is considered to be laid off from employment if there is a reduction in hours to the point where the employee is no longer eligible for coverage under the group life insurance policy. Termination does not include discharge for gross misconduct.

Subd. 2. [RESPONSIBILITY OF EMPLOYEE.] Every covered employee electing to continue coverage shall pay the employee's former employer, on a monthly basis, the cost of the continued coverage. In no event shall the amount of premium charged exceed 102 percent of the cost to the plan for such period of

coverage for other similarly situated employees with respect to whom neither termination nor layoff has occurred, without respect to whether such cost is paid by the employer or employee. The employee is eligible to continue the coverage until the employee obtains coverage under another group policy, or for a period of 18 months after the termination or layoff from employment, whichever is shorter.

Subd. 3. [NOTICE OF OPTIONS.] Upon termination of or layoff from employment of a covered employee, the employer shall inform the employee of:

(1) the employee's right to elect to continue the coverage;

(2) the amount the employee must pay monthly to the employer to retain the coverage;

(3) the manner in which and the office of the employer to which the payment to the employer must be made; and

(4) the time by which the payments to the employer must be made to retain coverage.

The employee has 60 days within which to elect coverage. The 60-day period shall begin to run on the date coverage would otherwise terminate or on the date upon which notice of the right to coverage is received, whichever is later.

Notice must be in writing and sent by first class certified mail to the employee's last known address which the employee has provided to the employer.

A notice in substantially the following form is sufficient: "As a terminated or laid off employee, the law authorizes you to maintain your group insurance benefits for a period of up to 18 months. To do so, you must notify your former employer within 60 days of your receipt of this notice that you intend to retain this coverage and must make a monthly payment of $..... at ..... by the ..... of each month."

Subd. 4. [RESPONSIBILITY OF EMPLOYER AND INSURER.] If the employer fails to notify a covered employee of the options set forth in subdivision 3, or if after timely receipt of the monthly payment from a covered employee the employer fails to make the payment to the insurer, with the result that the employee's coverage is terminated, the employer is still liable for the employee's coverage to the same extent as the insurer would be if the coverage were still in effect.

Subd. 5. [CONVERSION TO INDIVIDUAL POLICY.] A group insurance policy that provides postermination or layoff coverage as required by this section must also include a provision allowing a covered employee, surviving spouse, or

dependent at the expiration of the posttermination or layoff coverage provided by subdivision 2 to obtain from the insurer offering the group policy, at the employee's, spouse's, or dependent's option and expense, without further evidence of insurability and without interruption of coverage, an individual policy of insurance contract providing the same or substantially similar benefits.

A policy providing reduced benefits at a reduced premium rate may be accepted by the employee, the spouse, or a dependent in lieu of the coverage otherwise required by this subdivision.

Sec. 43. Minnesota Statutes 1986, section 61A.28, subdivision 12, is amended to read:

Subd. 12. [ADDITIONAL INVESTMENTS.] Investments of any kind, without regard to the categories, conditions, standards, or other limitations set forth in the foregoing subdivisions and section 61A.31, subdivision 3, except that the prohibitions in clause (d) of subdivision 3 remains applicable, may be made by a domestic life insurance company in an amount not to exceed the lesser of the following:

(1) Five percent of the company's total admitted assets as of the end of the preceding calendar year, or

(2) Fifty percent of the amount by which its capital and surplus as of the end of the preceding calendar year exceeds $675,000. Provided, however, that a company's total investment under this section in the common stock of any corporation, other than the stock of the types of corporations specified in subdivision 6(a), may not exceed ten percent of the common stock of the corporation. Provided, further, that no investment may be made under the authority of this clause or clause (1) by a company that has not completed five years of actual operation since the date of its first certificate of authority.

If, subsequent to being made under the provisions of this subdivision, an investment is determined to have become qualified or eligible under any of the other provisions of this chapter, the company may consider the investment as being held under the other provision and the investment need no longer be considered as having been made under the provisions of this subdivision.

In addition to the investments authorized by this subdivision, a domestic life insurance company may make qualified investments in any additional securities or property of the type authorized by subdivision 6, paragraph (f), with the written order of the commissioner. This approval is at the discretion of the commissioner. This authorization does not negate or reduce the investment authority granted in subdivision 6, paragraph (f), or this subdivision.

Sec. 45. Minnesota Statutes 1986, section 62A.041, is amended to read:

62A.041 [MATERNITY BENEFITS;-UNMARRIED-WOMEN.]

Each group policy of accident and health insurance and each group health maintenance contract shall provide the same coverage for maternity benefits to unmarried women and minor female dependents that it provides to married women including the wives of employees choosing dependent family coverage. If an unmarried insured or an unmarried enrollee is a parent of a dependent child, each group policy and each group contract shall provide the same coverage for that child as that provided for the child of a married employee choosing dependent family coverage if the insured or the enrollee elects dependent family coverage.

Each individual policy of accident and health insurance and each individual health maintenance contract shall provide the same coverage for maternity benefits to unmarried women and minor female dependents as that provided for married women. If an unmarried insured or an unmarried enrollee is a parent of a dependent child, each individual policy and each individual contract shall also provide the same coverage for that child as that provided for the child of a married insured or a married enrollee choosing dependent family coverage if the insured or the enrollee elects dependent family coverage.

Except for policies which only provide coverage for specified diseases, each group subscriber contract of accident and health insurance or health maintenance contract, issued or renewed after August 1, 1987, shall include maternity benefits in the same manner as any other illness covered under the policy or contract.

For the purposes of this section, the term "maternity benefits" shall not include elective, induced abortion whether performed in a hospital, other abortion facility, or the office of a physician.

This section applies to policies and contracts issued, delivered, or renewed after August 1, 1985, that cover Minnesota residents.

Sec. 46. Minnesota Statutes 1986, section 62A.043, is amended by adding a subdivision to read:

Subd. 3. Except for policies which only provide coverage for specified diseases, no policy or certificate of health, medical, hospitalization, or accident and sickness insurance regulated under this chapter, or subscriber contract provided by a nonprofit health service plan corporation regulated under chapter 62C, or health maintenance organization regulated under chapter 62D, shall be issued, renewed, continued, delivered,

issued for delivery, or executed in this state after August 1, 1987, unless the policy, plan, or contract specifically provides coverage for surgical and nonsurgical treatment of temporomandibular joint disorder and craniomandibular disorder. Coverage shall be the same as that for treatment to any other joint in the body, and shall apply if the treatment is administered or prescribed by a physician or dentist.

Sec. 47. Minnesota Statutes 1986, section 62A.141, is amended to read:

62A.141 [COVERAGE FOR HANDICAPPED DEPENDENTS.]

No group policy or plan of health and accident insurance regulated under this chapter, chapter 62C, or 62D, which provides for dependent coverage may be issued or renewed in this state after August 1, 1983, unless it covers the handicapped dependents of the insured, subscriber, or enrollee of the policy or plan. Consequently, the policy or plan shall not contain any provision concerning preexisting condition limitations, insurability, eligibility, or health underwriting approval concerning handicapped dependents.

If ordered by the commissioner of commerce, the insurer of a Minnesota-domiciled nonprofit association which is composed solely of agricultural members may restrict coverage under this section to apply only to Minnesota residents.

Sec. 48. Minnesota Statutes 1986, section 62A.146, is amended to read:

62A.146 [CONTINUATION OF BENEFITS TO SURVIVORS.]

No policy or plan of accident and health protection issued by an insurer, nonprofit health service plan corporation, or health maintenance organization, providing coverage of hospital or medical expense on either an expense incurred basis or other than an expense incurred basis which in addition to coverage of the insured, subscriber, or enrollee, also provides coverage to dependents, shall, except upon the written consent of the survivor or survivors of the deceased insured, subscriber or enrollee, terminate, suspend or otherwise restrict the participation in or the receipt of benefits otherwise payable under the policy or plan to the survivor or survivors until the earlier of the following dates:

(a) the date of remarriage of the surviving spouse becomes covered under another group health plan; or

(b) the date coverage would have terminated under the policy or plan had the insured, subscriber, or enrollee lived.

The survivor or survivors, in order to have the coverage and benefits extended, may be required to pay the entire cost of

the protection on a monthly basis. In no event shall the amount of premium or fee contributions charged exceed 102 percent of the cost to the plan for such period of coverage for other similarly situated spouses and dependent children who are not the survivors of a deceased insured, without regard to whether such cost is paid by the employer or employee. Failure of the survivor to make premium or fee payments within 90 days after notice of the requirement to pay the premiums or fees shall be a basis for the termination of the coverage without written consent. In event of termination by reason of the survivor's failure to make required premium or fee contributions, written notice of cancellation must be mailed to the survivor's last known address at least 30 days before the cancellation. If the coverage is provided under a group policy or plan, any required premium or fee contributions for the coverage shall be paid by the survivor to the group policyholder or contract holder for remittance to the insurer, nonprofit health service plan corporation, or health maintenance organization.

Sec. 49, Minnesota Statutes 1986, section 62A.152, subdivision 2, is amended to read:

Subd. 2. [MINIMUM BENEFITS.] All group policies and all group subscriber contracts providing benefits for mental or nervous disorder treatments in a hospital shall also provide coverage~~,~~ ~~to~~ on the same basis as coverage for other benefits for at least ~~the extent of~~ 80 percent of ~~the first $759~~ of the cost of the usual and customary charges of the first ten hours of treatment incurred over a 12-month benefit period, for mental or nervous disorder consultation, diagnosis and treatment services delivered while the insured person is not a bed patient in a hospital, and at least 75 percent of the cost of the usual and customary charges for any additional hours of treatment during the same 12-month benefit period for serious and persistent mental or nervous disorders, if the services are furnished by (1) a licensed or accredited hospital, (2) a community mental health center or mental health clinic approved or licensed by the commissioner of human services or other authorized state agency, or (3) a licensed consulting psychologist licensed under the provisions of sections 148.87 to 148.98, or a psychiatrist licensed under chapter 147. Prior authorization from an accident and health insurance company, or a nonprofit health service corporation, shall be required for an extension of coverage beyond ten hours of treatment. This prior authorization must be based upon the severity of the disorder, the patient's risk of deterioration without ongoing treatment and maintenance, degree of functional impairment, and a concise treatment plan. Authorization for extended treatment may not exceed a maximum of 30 visit hours during any 12-month benefit period.

For purposes of this section, covered treatment for a minor shall include treatment for the family if family therapy is recommended by a provider listed above in item (1), (2) or (3).

Sec. 50, Minnesota Statutes 1986, section 62A.17, is amended to read:

62A.17 [TERMINATION OF OR LAYOFF FROM EMPLOYMENT.]

Subdivision 1. [CONTINUATION OF COVERAGE,] Every group insurance policy, group subscriber contract, and health care plan included within the provisions of section 62A.16, except policies, contracts, or health care plans covering employees of an agency of the federal government, shall contain a provision which permits every eligible covered employee who is voluntarily or involuntarily terminated or laid off from employment, if the policy, contract, or health care plan remains in force for active employees of the employer, to elect to continue the coverage for the employee and dependents.

An employee shall be considered to be laid off from employment if there is a reduction in hours to the point where the employee is no longer eligible under the policy, contract, or health care plan. Termination shall not include discharge for gross misconduct.

Subd. 2. [RESPONSIBILITY OF EMPLOYEE.] Every eligible covered employee electing to continue coverage shall pay the former employer, on a monthly basis, the cost of the continued coverage. If the policy, contract, or health care plan is administered by a trust, every eligible covered employee electing to continue coverage shall pay the trust the cost of continued coverage according to the eligibility rules established by the trust. In no event shall the amount of premium charged exceed 102 percent of the cost to the plan for such period of coverage for similarly situated employees with respect to whom neither termination nor layoff has occurred, without regard to whether such cost is paid by the employer or employee. The employee shall be eligible to continue the coverage until reemployed-and-eligible-for-health-care-coverage under-a-group-policy,-contract,-or-plan-sponsored-by-the-same-or another-employer the employee becomes covered under another group health plan, or for a period of 12 18 months after the termination of or lay off from employment, whichever is shorter.

Subd.-3.--[ELIGIBILITY-FOR-CONTINUED-COVERAGE.]-An-employee shall-be-eligible-to-make-the-election-for-the-employee-and dependents-provided-for-in-subdivision-1-if:

(a)-in-the-period-preceding-the-termination-of-or-lay-off from-employment,-the-employee-and-dependents-were-covered through-employment-by-a-group-insurance-policy,-subscriber's contract,-or-health-care-plan-included-within-the-provisions-of section-62A.17;

(b)-The-termination-of-or-lay-off-from-employment-was-for reasons-other-than-the-discontinuance-of-the-business, bankruptcy,-or-the-employee's-disability-or-retirement;

Subd. 4. [RESPONSIBILITY OF EMPLOYER.] After timely receipt of the monthly payment from an ~~eligible~~ a covered employee, if the employer, or the trustee, if the policy, contract, or health care plan is administered by a trust, fails to make the payment to the insurer, nonprofit health service plan corporation, or health maintenance organization, with the result that the employee's coverage is terminated, the employer or trust shall become liable for the employee's coverage to the same extent as the insurer, nonprofit health service plan corporation, or health maintenance organization would be if the coverage were still in effect.

In the case of a policy, contract or plan administered by a trust, the employer must notify the trustee within 30 days of the termination or layoff of a covered employee of the name and last known address of the employee.

If the employer or trust fails to notify a covered employee, the employer or trust shall continue to remain liable for the employee's coverage to the same extent as the insurer would be if the coverage were still in effect.

Subd. 5. [NOTICE OF OPTIONS.] Upon the termination of or lay off from employment of an eligible employee, the employer shall inform the employee within ten days after termination or lay off of:

(a) the right to elect to continue the coverage;

(b) the amount the employee must pay monthly to the employer to retain the coverage;

(c) the manner in which and the office of the employer to which the payment to the employer must be made; and

(d) the time by which the payments to the employer must be made to retain coverage.

If the policy, contract, or health care plan is administered by a trust, the employer is relieved of the obligation imposed by clauses (a) to (d). The trust shall inform the employee of the information required by clauses (a) to (d).

The employee shall have 60 days within which to elect coverage. The 60-day period shall begin to run on the date plan coverage would otherwise terminate or on the date upon which notice of the right to coverage is received, whichever is later.

Notice may must be in writing and sent by first class mail to the employee's last known address which the employee has provided the employer or trust. ~~If the employer or trust fails to so notify the employee who is properly enrolled in the program, the employee shall have the option to retain coverage~~

~~if-the-employee-makes-this-election-within-60-days-of-the-date terminated-or-laid-off-by-making-the-proper-payment-to-the employer-or-trust-to-provide-continuous-coverage.~~

A notice in substantially the following form shall be sufficient~~:~~: "As a terminated or laid off employee, the law authorizes you to maintain your group medical insurance for a period of up to ~~12~~ 18 months. To do so you must notify your former employer within ten 60 days of your receipt of this notice that you intend to retain this coverage and must make a monthly payment of $..... to ..... at ..... by the ..... of each month."

Subd. 6, [CONVERSION TO INDIVIDUAL POLICY.] A group insurance policy that provides posttermination or layoff coverage as required by this section shall also include a provision allowing a covered employee, surviving spouse, or dependent at the expiration of the posttermination or layoff coverage provided by subdivision 2 to obtain from the insurer offering the group policy or group subscriber contract, at the employee's, spouse's, or dependent's option and expense, without further evidence of insurability and without interruption of coverage, an individual policy of insurance or an individual subscriber contract providing at least the minimum benefits of a qualified plan as prescribed by section 62E.06 and the option of a number three qualified plan, a number two qualified plan, and a number one qualified plan as provided by section 62E.06, subdivisions 1 to 3, provided application is made to the insurer within 30 days following notice of the expiration of the continued coverage and upon payment of the appropriate premium. The required conversion contract must treat pregnancy the same as any other covered illness under the conversion contract. A health maintenance contract issued by a health maintenance organization that provides posttermination or layoff coverage as required by this section shall also include a provision allowing a former employee, surviving spouse, or dependent at the expiration of the posttermination or layoff coverage provided in subdivision 2 to obtain from the health maintenance organization, at the former employee's, spouse's, or dependent's option and expense, without further evidence of insurability and without interruption of coverage, an individual health maintenance contract. Effective January 1, 1985, enrollees who have become nonresidents of the health maintenance organization's service area shall be given the option, to be arranged by the health maintenance organization, of a number three qualified plan, a number two qualified plan, or a number one qualified plan as provided by section 62E.06, subdivisions 1 to 3 if an arrangement with an insurer can reasonably be made by the health maintenance organization. This option shall be made available at the enrollee's expense, without further evidence of insurability and without interruption of coverage,

A policy providing reduced benefits at a reduced premium rate may be accepted by the employee, the spouse, or a dependent

in lieu of the optional coverage otherwise required by this subdivision.

The individual policy or contract shall be renewable at the covered under another qualified plan as defined in section 62E.02, subdivision 4, up to age 65 or to the day before the date of eligibility for coverage under title XVIII of the Social Security Act, as amended. Any revisions in the table of rate for the individual policy shall apply to the covered person's original age at entry and shall apply equally to all similar policies issued by the insurer.

Sec. 51. [62A,20] [COVERAGE OF CURRENT SPOUSE AND CHILDREN.]

Subdivision 1. [REQUIREMENT.] Every policy of accident and health insurance providing coverage of hospital or medical expense on either an expense-incurred basis or other than an expense-incurred basis, which in addition to covering the insured also provides coverage to the spouse and dependent children of the insured shall contain:

(1) a provision which permits the spouse and dependent children to elect to continue coverage when the insured becomes enrolled for benefits under Title XVIII of the Social Security Act (Medicare); and

(2) a provision which permits the dependent children to continue coverage when they cease to be dependent children under the generally applicable requirement of the plan:

Subd. 2. [CONTINUATION PRIVILEGE,] The coverage described in subdivision 1 may be continued until the earlier of the following dates:

(1) the date coverage would otherwise terminate under the policy;

(2) 36 months after continuation by the spouse or dependent was elected; or

(3) the spouse or dependent children become covered under another group health plan.

If coverage is provided under a group policy, any required premium contributions for the coverage shall be paid by the insured on a monthly basis to the group policyholder for remittance to the insurer. In no event shall the amount of premium charged exceed 102 percent of the cost to the plan for such period of coverage for other similarly situated spouse and dependent children to whom subdivision 1 is not applicable, without regard to whether such cost is paid by the employer or employee.

Sec. 52. Minnesota Statutes 1986, section 62A.21, is amended to read:

62A.21 [CONVERSION PRIVILEGES FOR INSURED FORMER SPOUSES AND CHILDREN.]

Subdivision 1. No policy of accident and health insurance providing coverage of hospital or medical expense on either an expense incurred basis or other than an expense incurred basis, which in addition to covering the insured also provides coverage to the spouse of the insured shall contain a provision for termination of coverage for a spouse covered under the policy solely as a result of a break in the marital relationship except ~~by-reason-of-an-entry-of-a-valid-decree-of-dissolution-of~~ marriage.

Subd. 2a. [CONTINUATION PRIVILEGE.] Every policy described in subdivision 1 shall contain a provision which permits continuation of coverage under the policy for the insured's former spouse and dependent children upon entry of a valid decree of dissolution of marriage~~,-if-the-decree-requires-the insured-to-provide-continued-coverage-for-those-persons~~. The coverage may shall be continued until the earlier of the following dates:

(a) The date ~~of-remarriage-of-either-the-insured-or~~ the insured's former spouse becomes covered under any other group health plan; or

(b) The date coverage would otherwise terminate under the policy.

If the coverage is provided under a group policy, any required premium contributions for the coverage shall be paid by the insured on a monthly basis to the group policyholder for remittance to the insurer. In no event shall the amount of premium charged exceed 102 percent of the cost to the plan for such period of coverage for other similarly situated spouses and dependent children with respect to whom the marital relationship has not dissolved, without regard to whether such cost is paid by the employer or employee.

Subd. 2b. [CONVERSION PRIVILEGE.] Every policy described in subdivision 1 shall contain a provision allowing a former spouse and dependent children of an insured, without providing evidence of insurability, to obtain from the insurer at the expiration of any continuation of coverage required under subdivision 2a or section sections 62A.146 and 62A.20, ~~or-upon termination-of-coverage-by-reason-of-an-entry-of-a-valid-decree of-dissolution-which-does-not-require-the-insured-to-provide continued-coverage-for-the-former-spouse-and-dependent-children~~, conversion coverage providing at least the minimum benefits of a qualified plan as prescribed by section 62E.06 and the option of a number three qualified plan, a number two qualified plan, a

number one qualified plan as provided by section 62E.06, subdivisions 1 to 3, provided application is made to the insurer within 30 days following notice of the expiration of the continued coverage and upon payment of the appropriate premium. A policy providing reduced benefits at a reduced premium rate may be accepted by the former spouse and dependent children in lieu of the optional coverage otherwise required by this subdivision. The individual policy shall be renewable at the option of the former spouse as long as the former spouse is not covered under another qualified plan as defined in section 62E.02, subdivision 4, up to age 65 or to the day before the date of eligibility for coverage under Title XVIII of the Social Security Act, as amended. Any revisions in the table of rate for the individual policy shall apply to the former spouse's original age at entry, and shall apply equally to all similar policies issued by the insurer.

Subd. 3. Subdivision 1 applies to every policy of accident and health insurance which is delivered, issued for delivery, renewed or amended on or after July 19, 1977.

Subdivisions 2a and 2b apply to every policy of accident and health insurance which is delivered, issued for delivery, renewed, or amended on or after August 1, 1981.

Sec. 53. Minnesota Statutes 1986, section 62A.27, is amended to read:

62A,27 [COVERAGE FOR ADOPTED CHILDREN.]

No individual or group policy or plan of health and accident insurance regulated under this chapter or chapter 64B, subscriber contract regulated under chapter 62C, or health maintenance contract regulated under chapter 62D, providing coverage for more than one person may be issued or renewed in this state after August 1, 1983, unless the policy, plan, or contract covers adopted children of the insured, subscriber, or enrollee on the same basis as other dependents. Consequently, the policy or plan shall not contain any provision concerning preexisting condition limitations, insurability, eligibility, or health underwriting approval concerning adopted children.

The coverage required by this section is effective from the date of placement for the purpose of adoption and continues unless the placement is disrupted prior to legal adoption and the child is removed from placement.

Sec. 55. Minnesota Statutes 1986, section 62A.31, subdivision 1a, is amended to read:

Subd. 1a. [APPLICATION TO CERTAIN POLICIES.] The requirements of sections 62A.31 to 62A.44 shall not apply to disability income protection insurance policies, long-term care policies issued pursuant to sections 62A.46 to 62A.56, or group

policies of accident and health insurance which do not purport to supplement medicare issued to any of the following groups:

(a) A policy issued to an employer or employers or to the trustee of a fund established by an employer where only employees or retirees, and dependents of employees or retirees, are eligible for coverage.

(b) A policy issued to a labor union or similar employee organization.

(c) A policy issued to an association, a trust or the trustee of a fund established, created or maintained for the benefit of members of one or more associations. The association or associations shall have at the outset a minimum of 100 persons; shall have been organized and maintained in good faith for purposes other than that of obtaining insurance; shall have a constitution and bylaws which provide that (1) the association or associations hold regular meetings not less frequently than annually to further purposes of the members, (2) except for credit unions, the association or associations collect dues or solicit contributions from members, and (3) the members have voting privileges and representation on the governing board and committees, and (4) the members are not, within the first 30 days of membership, directly solicited, offered, or sold a long-term care policy or Medicare supplement policy if the policy is available as an association benefit. This clause does not prohibit direct solicitations, offers, or sales made exclusively by mail.

Sec. 56. Minnesota Statutes 1986, section 62A.43, subdivision 2, is amended to read:

Subd. 2. [REFUNDS.] Notwithstanding the provisions of section 62A.38, an insurer which issues a medicare supplement plan to any person who has one plan then in effect, except as permitted in subdivision 1, shall, at the request of the insured, either refund the premiums or pay any claims on the policy, whichever is greater. Any refund of premium pursuant to this section or section 62A.38 shall be sent by the insurer directly to the insured within 15 days of the request by the insured.

Sec. 57. Minnesota Statutes 1986, section 62A.43, is amended by adding a subdivision to read:

Subd. 4. [OTHER POLICIES NOT PROHIBITED.] The prohibition in this section against the sale of duplicate Medicare supplement coverage does not preclude the sale of insurance coverage, such as travel, accident, and sickness coverage, the effect or purpose of which is not to supplement Medicare coverage. Notwithstanding this provision, if the commissioner determines that the coverage being sold is in fact Medicare supplement insurance, the commissioner shall notify the insurer

in writing of the determination. If the insurer does not thereafter comply with sections 62A.31 to 62A.44, the commissioner may, pursuant to chapter 14, revoke or suspend the insurer's authority to sell accident and health insurance in this state or impose a civil penalty not to exceed $10,000, or both.

Sec. 58. Minnesota Statutes 1986, section 62A.46, is amended by adding a subdivision to read:

Subd. 11. [BENEFIT PERIOD.] "Benefit period" means one or more separate or combined periods of confinement covered by a long-term care policy in a nursing facility or at home while receiving home care services. A benefit period begins on the first day the insured receives a benefit under the policy and ends when the insured has received no benefits for the same or related cause for an interval of 180 consecutive days.

Sec. 59. Minnesota Statutes 1986, section 62A.48, subdivision I, is amended to read:

Subdivision 1. [POLICY REQUIREMENTS.] No individual or group policy, certificate, subscriber contract, or other evidence of coverage of nursing home care or other long-term care services shall be offered, issued, delivered, or renewed in this state, whether or not the policy is issued in this state, unless the policy is offered, issued, delivered, or renewed by a qualified insurer and the policy satisfies the requirements of sections 62A.46 to 62A.56. A long-term care policy must cover medically prescribed long-term care in nursing facilities and at least the medically prescribed long-term home care services in section 62A.46, subdivision 4, clauses (1) to (5), provided by a home health agency. Coverage under a long-term care policy AA must include: a maximum lifetime benefit limit of at least $100,000 for services, and nursing facility and home care coverages must not be subject to separate lifetime maximums, and a requirement of prior hospitalization for up to one day may be imposed only for long-term care in a nursing facility. Coverage under a long-term care policy A must include: a maximum lifetime benefit limit of at least $50,000 for services, nursing facility and home care coverages must not be subject to separate lifetime maximums, and a requirement of prior hospitalization for up to three days may be imposed for long-term care in a nursing facility or home care services. If long-term care policies require the policyholder to be admitted to a nursing facility or begin home care services within a specified period after discharge from a hospital, that period may be no less than 30 days.

Coverage under either policy designation must cover preexisting conditions during the first six months of coverage if the insured was not diagnosed or treated for the particular condition during the 90 days immediately preceding the effective date of coverage. Coverage under either policy designation may

include a waiting period of up to 90 days before benefits are paid, but there must be no more than one waiting period per benefit period. No policy may exclude coverage for mental or nervous disorders which have a demonstrable organic cause, such as Alzheimer's and related dementias. No policy may require the insured to meet a prior hospitalization test more than once during a single benefit period. The policy must include a provision that the plan will not be canceled or renewal refused except on the grounds of nonpayment of the premium, provided that the insurer may change the premium rate on a class basis on any policy anniversary date. ~~Policy-options-include~~ A provision that the policyholder may elect to have the premium paid in full at age 65 by payment of a higher premium up to age 65 and may be offered. A provision that the premium would be waived during any period in which benefits are being paid to the insured during confinement in a nursing facility must be included. A nongroup policyholder may return a policy within 30 days of its delivery and have the premium refunded in full, less any benefits paid under the policy, if the policyholder is not satisfied for any reason.

Sec. 60. Minnesota Statutes 1986, section 62A.48, subdivision 2, is amended to read:

Subd. 2. [PER DIEM COVERAGE.] If benefits are provided on a per diem basis, the minimum daily benefit for care in a nursing facility must be the lesser of $60 or actual charges under a long-term care policy AA or the lesser of $40 or actual charges under a long-term care policy A and the minimum daily benefit per visit for home care under a long-term care policy AA or A must be the lesser of $25 or actual charges ander-a ~~long-term-care-policy-AA-or-the-lesser-of-$25-or-actual-charges for-nurse-and-therapy-services-and-$29-for-home-health-aide-and nonmedical-services-under-a-long-term-care-policy-A.--If-home care-services-are-provided-less-frequently-than-daily,-the minimum-benefit-is-the-lesser-of-actual-charges-or-an-amount determined-by-multiplying-the-number-of-days-of-the-period during-which-services-will-be-provided,-or-a-reasonable-interval of-the-service-period,-by-$25-and-dividing-the-resulting-amount by-the-number-of-days-during-this-period-on-which-home-care services-were-rendered.~~ The home care services benefit must cover at least seven paid visits per week.

Sec. 61. Minnesota Statutes 1986, section 62A.48, subdivision 6, is amended to read:

Subd. 6. [COORDINATION OF BENEFITS.] A long-term care policy ~~shall~~ may be secondary coverage for services provided under sections 62A.46 to 62A.56. Nothing in sections 62A.46 to 62A.56 shall require the secondary payor to pay the obligations of the primary payor nor shall it prevent the secondary payor from recovering from the primary payor the amount of any obligation of the primary payor that the secondary payor elects to pay.

There shall be no coordination of benefits between a long-term care policy and a policy designed primarily to provide coverage payable on a per diem, fixed indemnity or nonexpense-incurred basis, or a policy that provides only accident coverage.

Sec. 62. Minnesota Statutes 1986, section 62A.48, is amended by adding a subdivision to read:

Subd. 7. [EXISTING POLICIES.] Nothing in sections 62A.46 to 62A.56 prohibits the renewal of policies sold outside the state of Minnesota to persons who at the time of sale were not residents of the state of Minnesota.

Sec. 63. Minnesota Statutes 1986, section 62A.50, subdivision 3, is amended to read:

Subd. 3. [DISCLOSURES.] No long-term care policy shall be offered or delivered in this state, whether or not the policy is issued in this state, and no certificate of coverage under a group long-term care policy shall be offered or delivered in this state, unless a statement containing at least the following information is delivered to the applicant at the time the application is made:

(1) a description of the benefits and coverage provided by the policy and the differences between this policy, a supplemental medicare policy and the benefits to which an individual is entitled under parts A and B of medicare and the differences between policy designations A and AA;

(2) a statement of the exceptions and limitations in the policy including the following language, as applicable, in bold print: "THIS POLICY DOES NOT COVER ALL NURSING CARE FACILITIES OR NURSING HOME OR HOME CARE EXPENSES AND DOES NOT COVER RESIDENTIAL CARE. READ YOUR POLICY CAREFULLY TO DETERMINE WHICH FACILITIES AND EXPENSES ARE COVERED BY YOUR POLICY.";

(3) a statement of the renewal provisions including any reservation by the insurer of the right to change premiums;

(4) a statement that the outline of coverage is a summary of the policy issued or applied for and that the policy should be consulted to determine governing contractual provisions;

(5) an explanation of the policy's loss ratio including at least the following language: "This means that, on the average, policyholders may expect that $..... of every $100 in premium will be returned as benefits to policyholders over the life of the contract."; and

(6) a statement of the out-of-pocket expenses, including deductibles and copayments for which the insured is responsible, and an explanation of the specific out-of-pocket expenses that

may be accumulated toward any out-of-pocket maximum as specified in the policy.

Sec. 86. Minnesota Statutes 1986, section 64B.11, subdivision 4, is amended to read:

Subd. 4. [FILING OF AMENDMENTS BY FOREIGN OR ALIEN SOCIETY.] Every foreign or alien society authorized to do business in this state shall ~~file with the commissioner a duly certified copy of all amendments of, or additions to, its laws within 90 days after the enactment of same~~ be subject to the requirements of section 72A.061, subdivision 2, as to amendments or additions to its bylaws.

Sec. 87. Minnesota Statutes 1986, section 64B.18, is amended to read:

64B.18 [BENEFITS NOT ATTACHABLE.]

~~Except as provided in chapter 256B, the money or other benefits, charity, relief, or aid to be paid, provided, pr rendered by any society authorized to do business under this chapter shall, neither before nor after being paid, be liable to attachment, garnishment, or other process and shall not be ceased, taken, appropriated, or applied by any legal or equitable process or operation of laws to pay any debt or liability of a certificate holder or of any beneficiary named in the certificate, or of any person who may have any right thereunder.~~ The cash value, proceeds, or benefits under any matured or unmatured life insurance or annuity contract issued before, on, or after the effective date of this section, by any society authorized to do business under this chapter, is exempt from attachment, garnishment, execution, or other legal process to the extent provided by section 550.37, subdivisions 10, 23, and 24.

Sec. 88. Minnesota Statutes 1986, section 64B.27, is amended to read:

64B.27 [ANNUAL LICENSE.]

Societies that are now authorized to transact business in this state may continue this business until the first day of June next succeeding August 1, 1985. The authority of the societies and all societies hereafter licensed, may thereafter be renewed annually, subject to section 60A.13, subdivisions 1, 5, 6, and 7. However, a license so issued shall continue in full force and effect until the new license is issued or specifically refused. ~~For each license or renewal the society shall pay the commissioner $99.~~ A duly certified copy or duplicate of the license is prima facie evidence that the licensee is a fraternal benefit society within the meaning of this chapter.

Sec. 119. Minnesota Statutes 1986, section 72A.20, is amended by adding a subdivision to read:

Subd. 19. [SUPPORT FOR UNDERWRITING STANDARDS.] No life or health insurance company doing business in this state shall engage in any selection or underwriting process unless the insurance company establishes beforehand substantial data, actuarial projections, or claims experience which support the underwriting standards used by the insurance company. The data, projections, or claims experience used to support the selection or underwriting process is not limited to only that of the company. The experience, projections, or data of other companies or a rate service organization may be used as well.

Sec. 129. [APPLICATION.]

Sections 49, 65, and 66 apply to all group policies, all group subscriber contracts, all health maintenance contracts, and all qualified plans within the scope of Minnesota Statutes, chapters 62A, 62C, 62D, and 62E, that are issued, delivered or renewed in this state after August 1, 1987.